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Interpersonal interactions of depressives

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CHAPTER 6

Discussion

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Discussion

In order to better understand the course and development of depression, research has been conducted into the interpersonal interactions depressed persons have with others. In this thesis, attention was given to interpersonal interaction behaviors of remitted depressed patients and the relationship of these behaviors with relapse. Furthermore, attention was also given to the interpersonal strategies and behavioral interactions of depressed patients with their partners and strangers.

In this chapter, I will briefly discuss the results of the studies described in chapters two, three, four and five. Then an integration of these results will be discussed and future research directions will be considered.

Interpersonal behavior and depression relapse

In **chapter two** it is found that those remitted patients that relapsed back into depression during the six months after they had left the hospital, displayed less Active Listening during an interview at discharge than those that did not relapsed. It was also noted that none of the other behavioral factors of the patients or any behavioral factors of the interviewers were related to the occurrence of relapse.

In similar behavioral research it was found that depressed patients who did not recover after ten weeks of treatment displayed less Active Listening during a pre-treatment interview than patients that did improve (Bouhuys et al., 1992). Hence, it is proposed in **chapter two** that Active Listening deficits constitute a behavioral vulnerability factor for the development and maintenance of depression.

As mentioned, the behaviors of the interviewer and those of the patients, except for Active Listening of the latter, did not hold predictive qualities with respect to the occurrence of relapse. In previous studies of depressed patients (Bouhuys et al., 1993; Geerts et al., 1995) it was found that the behavioral factors Speaking Effort (support-seeking behavior) and Encouragement (support-giving behavior) did have predictive qualities with respect to the course of depression. They were clearly related to the effects of ten weeks of clinical treatment. On first sight, these data seem to be at variance with the data presented in **chapter two**. It is suggested, however, that differences in research designs may account for these discrepancies, such as the interviewers' (non-) relatedness with the treatment and the moment at which the

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interviews took place. It may well be that these behavioral factors are of influence in the context of the therapeutic process the patients and the interviewers are involved in, and not in the “non-therapeutic” context of everyday life after discharge.

Interpersonal behaviors and strategies of depressed patients, their partners and controls

The findings presented in **chapter three** are discussed within the framework of the role of social support in the mechanisms underlying the onset and the course of depression. It is suggested that observable behaviors that express the seeking and giving of social support may shed light on the interactions that facilitate the development and persistence of depression.

It was found that partners of depressed patients showed less support-giving behavior (Encouragement) in their interaction with the patients than did controls (who were matched on the age and the sex of the partner). Moreover, the patients displayed less support-seeking behavior (Speaking Effort) in their interactions with their partners than in those with their partners' controls. These findings are in line with other data that demonstrate that patients display less involvement in their interactions with their partners than in those with strangers (Hinchliffe et al., 1975; Hinchliffe et al., 1977).

In the context of Coyne's interpersonal theory of depression (1976; 1991), these findings may help to identify behavioral features of the two stages of the depressogenic process. The support-seeking and giving behaviors during the patient-control interactions might represent the early stage of the process, and that the lower levels of support-seeking and giving behaviors in the patient-partner interactions might represent the later stage. Nevertheless, alternative explanations are possible. The relatively high involvement shown in the patient-control interaction might reflect socially desirable behavior on the part of the participants. However, in healthy subjects this interpretation seems not to be corroborated (Fitzpatrick et al., 1986). Our interpretation of decreasing support-seeking behavior as a characteristic of a later stage in the course of depression, is in line with the finding that depressives tend to communicate more negatively with their partners than with others (Segrin et al., 1994). A control group of healthy persons, matched on the age and sex of the patients, interacting with their partner and with their partner's control would have given us

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more insight in this respect. However, such data collection was outside the means of this study.

In **chapter four**, research was conducted into the judgment of facial expressions by depressed patients, their partners and matched controls, in order to study the underlying interpersonal interaction strategies they employ. In this study it was found that both patients and partners judged less positive emotions than did the controls for both general and ambiguous facial expressions and in addition the patients and the partners did not judge these emotions differently.

While some studies have found a negative bias for the judgment of facial expressions by depressives (Nandi et al., 1982; Gur et al., 1992), other studies have not (Walker et al., 1984; Archer et al., 1992; Bouhuys et al., 1996). In a different light, it has been suggested that it is not so much a negative bias on the part of the depressed person as much as it is a positive bias on the part of the not-depressed person (Matthews et al., 1992), although this has been disputed (McCabe et al., 1995). Our findings could be interpreted as being supportive of a negative bias on the part of the depressives as well as being supportive of a positive bias on the part of the controls.

Of particular interest are results on the judgment of the partner: findings that would seem to indicate that the judgments of partners and depressed patients are similar. As previously mentioned, in general the (social support) interactions between depressives and others has been found to be problematic (McNaughton et al., 1992) and specifically between patients and their partners (Hooley et al., 1989), possibly due to the patients focus on negative aspects of their social surroundings (Gotlib et al., 1992). In light of these findings, one may argue that depressives have influenced the partners' judgments and vice versa. Interpersonal theories of depression assume that depressives ultimately induce rejection from others, such as their partners (Coyne et al., 1991; Segrin et al., 1992), and that such an induction may have influenced the partners' mood. Indeed, we found that the partners tended to be more depressed than the controls, but this may also be due to the selection criteria for the controls.

In **chapter five**, the interpersonal interactions of a sample of depressed outpatients and their partners, as compared to that of a sample of healthy controls, was explored by means of an Expressed Emotion (EE) measure: the Level of Expressed

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Emotion (LEE; Cole et al., 1988) questionnaire. In this study it was found that perceived EE was a significant predictor of the course of the patients' depression.

The clinical and healthy sample displayed different relationships between perceived EE and coping styles. Healthy controls who used a coping style of depressive reaction and avoidance were likely to perceive more EE; they also perceived more EE when their partners used depressive reaction and expression of emotion coping styles. This finding was in contrast to the finding that EE perceived by the patient was only related to support seeking, as measured with the self rating scale for coping styles: patients who perceived high levels of EE tended to use this coping style less.

A tentative explanation for these differences is given in respect to the dynamic interaction process aspect of interpersonal depression theories; once a vulnerability for depression has developed, the individual is likely to end up in a vicious circle in which depressive support seeking tends to meet with detrimental responses, such as rejection (Coyne et al., 1991). If the LEE scales, in particular the criticism and irritability scales, are fair measures of such (expected or perceived) detrimental responses, the results found in the healthy sample of this study might reflect a lenient stage of the interaction process, where a depressive reacting coping style is related with the perception of EE. Couples from the clinical sample may find themselves in a more desperate stage in this dynamic process, where patients may seek support only when they expect a favorable response, whereas those who have learned to expect criticism and irritability in response to (self-rated) support seeking refrain from doing so. Giving up on this may have impeded early recovery: the more EE the patients perceived, the less they reported support seeking and the less they improved in the course of the following six months.

An integration of the findings and future research directions

Active Listening and Social Support

As mentioned in a former paragraph there is some evidence that low levels of Active Listening on the part of the patient might be a vulnerability factor for the development and maintenance of depression. I also mentioned some evidence that levels of support-seeking and support-giving behaviors are important for the course of

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depression. Do the data presented in this thesis provide evidence that these behaviors are related?

In the study described in **chapter two** it was found that low levels of Active Listening of remitted patients, as displayed in an interview at the time of discharge, are related to depression relapse in a period of six months after the interview. It is conceivable that Active Listening is a behavioral factor which, when displayed in low levels, signals a need for support. When examined in the context of Coyne's interpersonal theory with its vicious circle of the depressed person displaying depressive behaviors in order to elicit supportive behavior from others until this support is withdrawn, one could hypothesize that the remitted patients that would relapse were signaling a need for support in the interview, a need that went unanswered after discharge, helping to partially explain their relapse. In the case of the patients that did not relapse, no such need may have existed, possibly because they were not involved in the vicious circle any more, which may in part explain the stability of their remission.

Some data from the study presented in **chapter three** may shed more light on this issue. Depressed outpatients displayed less Active Listening in their interactions with the strangers than in interactions with their partners. At the same time, the patients displayed more support-seeking behavior in their encounters with the strangers than in those with their partners. On the other hand, the strangers showed less Active Listening than the partners, while they showed more support-giving behavior. One can speculate that these two different interactions represent different stages of the depressogenic process. The interactions between patients and strangers might be the manifestation of the start of the vicious circle, whereas those between patients and partners might represent a later stage. In the first phase of the depressogenic process the patient would display a combination of less Active Listening and more support-seeking behavior, while the partner would display a combination of less Active Listening and more support-giving behavior. In a later phase the patients would show more Active Listening and less support-seeking behavior and their partners more Active Listening and less support-giving behavior. Studies of patient-partner interactions in different phases of a depression may elucidate the importance of Active Listening and its relationship to the seeking and receiving of support.

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There are more data that question the role of Active Listening in this respect. As was noted for depressed in-patients taking part in a clinical interview, low Active Listening is predictive of less improvement and more relapse. This was, however, not found in the study of depressed outpatients in **chapter three**. The same discrepancy is found in respect to the data on support-seeking and support-giving behaviors. Whereas these behaviors did show a relationship with response to treatment in other studies, they did not in the study presented in **chapter three**. While the speech behavior of the partners predicted remission, none of the other behaviors of the partners, of the partners' controls, or of the patients themselves had predictive properties with respect to the patients' state within six months. Again, contextual differences may be responsible for these discrepancies. Evidently, the interactions between patients, their partners and the strangers were not part of a therapeutic procedure: the topics of the conversation were neutral, i.e. they did not concern clinical subjects, partners and strangers were not involved in diagnostic procedures, and so on. Furthermore, it is quite likely that these behaviors play different roles in the different contexts subsequent to the interview: therapeutic procedures or everyday life.

Other designs will be necessary to elucidate the role of Active Listening and the behaviors reflecting the seeking and giving of support. Research of patients in three types of interaction, i.e. interactions with a clinical interviewer, with the partner and with the partner's control, during the patients stay at hospital (to study therapy outcome) and after discharge in remitted condition would be helpful in this respect. Furthermore, the interactions between patients, their partners and the partners' controls, at the time of hospital admission and at the time of discharge, could be compared with the interactions between healthy persons, matched on the age and sex of the patients and their partners and partners' controls, in similar time frames.

Finally, it should be remarked that there is accumulating evidence that the attunement of behaviors between patients and others is also of importance. Particularly, the level and the course of time of the attunement between the patient's Speaking Effort, i.e. his support-seeking behavior, and the interviewer's Encouragement, i.e. his support-giving behavior, appears to be critical: the more patients and interviewers get attuned in this respect, the more favorable the subsequent course of depression will be (Geerts et al., 1996; Geerts et al., 1997).

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Interpersonal interaction strategies

In addition to the social support that depressed patients seek and receive more from controls than from their own partner, as noted in **chapter three**, attention was also given to measures that may help to better explain the interpersonal interaction strategies that depressives and others have with one another. In **chapter four** it is found that patients and partners judge both general and ambiguous facial expressions less positively than controls and it is suggested that this may be due to a negative bias on the part of the patients and their partners or due to a positive bias on the part of the controls. It is suggested that such judgments are reflective of how patients determine signals from others during an interaction and, hence, are of influence on how these others then react. In **chapter five** it is suggested that the more EE the depressed patients perceived in their partner, the less they reported (self rated) support seeking and the less they improved in the course of the following six months. It should be remarked in this context that self rated support seeking evidently can not be equated to observed support-seeking behavior: high levels of Speaking Effort and/or low levels of Active Listening. As we have seen, these latter variables were not predictive with respect to the course of depression in the same patient group. Moreover, the outcome measures in the EE study reported in **chapter five** were different than those in the behavioral study reported in **chapter three**.

The interpersonal theory of depression (Coyne et al., 1991) holds that a depressed patient continually displays more depressive behaviors in an attempt to elicit more support from others due to the patient's belief that the received support is intermixed with underlying rejection. In view of the findings of **chapters four and five**, it would appear that patients receive rejection at home, as reflected by EE, and this leads the patient to seek support only when a favorable response is expected, whereas those who have learned to expect the rejection of EE in response refrain from doing so. Additionally, the depressed patient and their partner both seemingly have a negative bias in regard to judgment of interpersonal interaction signals: a bias which conceivably influences their interaction with one another.

In the future research direction described above, for the interpersonal interactions of depressed patient populations, it is imaginable that additional measures, such as the LEE and the judgment of facial expressions may hold potentially valuable information. For example, it is possible that high premorbid levels of EE, as measured

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by the LEE, in a person's household may help initiate the vicious circle of depressive interactions: both the depressive and their partner tend to judge interaction signals of the other negatively and tend to display less support to one another. Such additions to the aforementioned research design may then require an extra measurement point before the depressed patients become depressed. A prospective study utilizing persons at risk for depression development may be helpful in this regard.

Concluding remarks

In conclusion, the study of interpersonal interaction behaviors of depressed patients may underline the significance of interpersonal mechanisms in the initiation and maintenance of depression. Future research may help to enhance our understanding of such mechanisms by detecting subtle nonverbal communicative features of depressogenic interactions and thereby helping us to better understand how social support is effected in interactions between depressed patients and others.

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